Testimony to the Public Health Committee

Presented by Mag Morelli, President of LeadingAge Connecticut

March 28, 2022

Regarding

Senate Bill 477, An Act Concerning the Public Health of Residents of the State
&
House Bill 5500, An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes

Good morning, Senator Anwar, Representative Steinberg and members of the Public Health Committee. My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership association representing not-for-profit provider organizations serving older adults across the continuum of aging services, including not-for-profit skilled nursing facilities, residential care homes, home health care agencies, hospice agencies, adult day centers, assisted living communities, senior housing and life plan communities. I am pleased to be here to testify on two of the bills before you today.

Senate Bill 477, An Act Concerning the Public Health of Residents of the State

Regarding Senate Bill 477, I would like to speak to Sections 1 and 2 of the bill which relate to assisted living communities and dementia special care units and programs.

Assisted living communities offer a level of care and services to a population of older adults whose physical or mental health conditions are considered chronic and stable. LeadingAge Connecticut has several members who offer assisted living as part of the continuum of aging services offered by their organizations. Some offer the services as part of a Life Plan Community (also known as a "Continuing Care Retirement Community" or "CCRC") and others offer it as either a free-standing model or as part of an affordable housing with services model.

Assisted living is state regulated and all 50 states have some form of regulation or licensure category for assisted living, although it may not be called by that name. Connecticut's model of assisted living was designed many years ago and is considered unique among state models in that it licenses the Assisted Living Services Agency (ALSA) and separately places conditions on the Managed Residential Community (MRC) which is the actual building, most often an apartment style building, where ALSA services are delivered. This model has served the state well over the years and has allowed us to deliver assisted living services in a variety of settings, including the affordable housing setting.

Our statutes related to assisted living have been amended over the years through the addition of specific laws governing the MRC, including contract requirements and resident rights, as well as requirements for dementia special care units and programs (which are often referred to as "memory care units" in the assisted living setting). An example of this is the recent requirement that dementia special care units and programs in the assisted living setting obtain Department of Public Health (DPH) approval and that they employ an infection preventionist adopted in PA 21-121 and 21-185 respectively. While we have modified the model through these incremental statutory changes, we recognize that there may be a desire to implement more comprehensive changes, particularly concerning dementia special care units or programs. **We can appreciate that perspective, but we respectfully ask the Committee not to make these changes at this time and to first conduct a holistic review of the current statutory and regulatory construct that oversees this model.**

Toward that goal, we know that the ALSA regulations contained in the Public Health Code are scheduled to be revised by DPH. To assist in this effort, we would suggest that work be done now to conduct a thorough, holistic and collaborative review of the regulations so as to assist in a swift revision to the regulations. LeadingAge Connecticut and our members, many of which are national leaders in the field of dementia care, would be eager and willing to participate in such a review.

Assisted living is primarily private pay and is a growing sector of the aging services field. It is designed to provide assistance with daily living, but it is not intended to be, nor licensed to provide, skilled nursing home care. The assisted living model is designed to transition the MRC resident to a higher level of care when their condition is no longer chronic and stable. That higher level of care may be provided either in the resident's apartment by a home health care agency, hospice agency or a private duty nursing provider, or by moving into a skilled nursing facility. It is important that consumers understand this when they enter into their lease and service agreements with assisted living communities and that is why our statutes contain strong consumer disclosure requirements.

Our objections to the bill before you today are focused on Section 2 (c), (d), and (g), which propose to establish minimum staffing levels for ALSAs providing services in dementia special care units or programs, staffing level posting requirements, and specific required content for the daily notes maintained on each client of the ALSA. These proposals appear to be ideas taken from the current requirements of the skilled nursing home setting.

While we support a review of the current assisted living model, we oppose the concept of layering nursing home-oriented regulation onto this level of care. What we object to is the transformation of assisted living communities into skilled nursing home like settings. Skilled nursing is a critical segment of the aging and health care continuum. It is highly regulated and is licensed and certified to care for individuals in need of skilled nursing care. We have skilled nursing home licensure; we do not need to transform assisted living communities into skilled nursing settings.

Regarding the proposal to establish minimum staffing levels, there currently is regulatory oversight of ALSA staffing levels. There are minimum requirements of licensed staff hours in the public health code regulations and DPH is charged with ensuring that each ALSA has adequate

staff to meet the needs of their clients. We appreciate this concept as it judges the staffing in accordance with the specific programming models, as well as the level of care needs which can vary widely amongst ALSA clients. In addition, all ALSA providers are required to disclose their staffing plans to DPH. With regard to memory care services in assisted living, we do believe that the consumer should be made aware of the type of service model provided by the community and that is why the ALSAs providing services in a dementia special care unit or program must have such programs approved by DPH and must complete and provide to residents a comprehensive disclosure form which DPH is authorized to annually review and verify for accuracy. This bill calls for the ALSA to distribute written updates to their disclosure form and we do not oppose this idea.

Regarding the maintenance of daily records, ALSAs currently maintain daily records of their memory care clients, including medication records. We appreciate the effort to enhance this practice, but the core items to be included in these records that are listed in this proposal may not be applicable to all memory care residents. Many individuals, even on memory care units, function independently with regard to their meal and bathing schedules. We assert that the core items to be maintained in a health care record are more appropriately outlined in regulation and we would suggest addressing this in the Public Health Code revision.

Living with Alzheimer's or other forms of dementia may be a challenging journey. The goal of LeadingAge member providers is to help the older adult living with dementia and their families adapt to the changes and challenges, keeping life meaningful at every stage. We ask that you allow us to engage with you in the review of memory care provided through the assisted living sector, as we did when the original dementia special care unit or program requirements were developed, so as to advance positive updates to the current Public Health Code regulations.

House Bill 5500, An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes

Regarding House Bill 5500, I would like to speak to Section 36 which seeks modifications to the staffing level provisions for skilled nursing facilities included in Public Act 21-185, *An Act Concerning Nursing Homes and Dementia Special Care Units*, which is codified in Conn. Gen. Stat. § 19a-563h.

We respectfully request that as the Committee addresses needed modifications to this statute through Section 36, that you also amend the language related specifically to the new social worker staffing levels. We are proposing amending the language so as to enable the Department of Public Health to apply the new social worker staffing levels proportionately to the individual nursing home's resident census. The Public Health Code has previously outlined required social worker staffing in proportional levels and we request enabling legislation to continue current practice.

We suggest the following language to amend lines 996-1003 of the bill*: (a) On or before January 1, 2022, the Department of Public Health shall (1) establish minimum staffing level requirements for nursing homes of three hours of direct care per resident per day, and (2) modify staffing level requirements for social work and recreational staff of nursing homes such that the requirements (A) for social work,* ***hours that*** *are* ***based on*** *one full-time social worker per sixty residents* ***and***

that will vary proportionally based on resident census, *and (B) for recreational staff are lower than the current requirements, as deemed appropriate by the Commissioner of Public Health.*

We also respectfully suggest that the Committee consider including in this bill the substitute language placed in Senate Bill 371 regarding modifications to the infection preventionist staffing levels and to the assisted living services provided in the affordable HUD assisted senior housing sites. In that both proposals are germane to the issues contained in House Bill 5500, it could make sense to include the language of SB 371 into this bill. We are very appreciative of the support of the committee in approving SB 371.

We view the changes above as minor modifications to the existing statutes, designed to accommodate operational and workforce realities. We have discussed the suggestions with the Department of Public Health and have been cautious to ensure the modifications kept within the spirit of the laws adopted. We urge your support for these much-needed changes.

We thank you for this opportunity to testify on these bills and for your consideration of our opinion.

Respectfully submitted,

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